INTRAMED Plus
infusion services

# ACTEMRA®
## Pediatrics (> 2 y.o.)

## INFUSION & MEDICAL CENTER

**1. Patient Name** _____ **DOB** _____ **Patient Phone/Cell #** _____

**Patient demographic and insurance information to be faxed with Infusion Order Form**

**2. Medical Information (Please select primary diagnosis and complete ICD10 Code):**

Primary Diagnosis: _____ Juvenile Rheumatoid Arthritis with Systemic Onset ICD-10 Code: M08.2 _____

_____ Juvenile Rheumatoid Polyarthritis (seronegative) ICD-10 Code: M08.3 _____

_____ Other:_____ ICD-10 Code: _____

Allergies:_____ (or attach list)

**Patient**
**Weight:** _____ lbs.
**Height:**_____ in.

**3. Clinical Information – Please fax with Infusion Order Form:**

- Clinical notes, labs, test supporting primary diagnosis
  - TB Screening Results
  - Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
  - Recent Lab Results (including CBC with diff, LFTs, Platelets, & Lipid Panel)
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration:

Agent: _____ Date:_____Desired Washout Period: _____ weeks

**Infusion Center – Lab Orders: (Check for Infusion Center to Manage):**

❑ CBC with diff, Platelets, and LFTs prior to second infusion and every _____ weeks.

❑ Lipid Panel prior to the second infusion and then every six months

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### ACTEMRA® (tocilizumab) J Code: J3262

**4. Drug Order:**

Administer Actemra IV over 1 hour. ***Select Dose Below***

**For Polyarticular JIA – Infuse every 4 weeks** _____#Refills (Recommend 5)

❑ Less Than 30 kg weight: **10 mg/kg**

❑ 30 kg or above weight: **8 mg/kg**

**For Systemic JIA – Infuse every 2 weeks** _____#Refills (Recommend 10)

❑ Less Than 30 kg weight: **12 mg/kg**

❑ 30 kg or above weight: **8 mg/kg**

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**Pre-Medication Orders:** _____

No Pre-medications are recommended based on manufacturer guidelines.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

**5. Physician Signature:** _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

| FAX ALL INFORMATION<br>CENTRAL FAX **803.999.1754** | **INFUSION CENTER LOCATIONS**<br>**BERKELEY CHARLESTON COLUMBIA GREENVILLE**<br>**CENTRAL INTAKE PHONE 803.999.1760** |
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